

# Discharge Information and Instruction Form

Facility    ☐ Catawba    ☐ CSH    ☐ CCCA    ☐ ESH    ☐ NVMHI    ☐ Piedmont    ☐ SVMHI    ☐ SwVMHI    ☐ WSH

Name: \_\_\_\_\_ Registration Number: \_\_\_\_\_

Legally Authorized Representative: \_\_\_\_\_ Relationship: \_\_\_\_\_

Case Management CSB: \_\_\_\_\_ Discharge CSB: \_\_\_\_\_  
(PRAIS CSB Code)

Admission Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Discharge Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Discharge Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_

Discharge Address: \_\_\_\_\_

Type of Placement: \_\_\_\_\_ Placement Code: \_\_\_\_-\_\_\_\_-\_\_\_\_  
(PRAIS Out Referral Code)

Signed Authorization to Release Information to Private Provider:      Yes      No      N/A

CSB Case Manager: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_

CSB Emergency Services Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_

First Appointment:      DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_      TIME: \_\_\_\_:\_\_\_\_AM/PM

Provider Type:    ☐ case manager    ☐ therapist    ☐ psychiatrist    ☐ other (specify): \_\_\_\_\_

Provider's Name: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Provider's Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_

Other Appointment:      DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_      TIME: \_\_\_\_:\_\_\_\_AM/PM

Provider Type:    ☐ case manager    ☐ therapist    ☐ psychiatrist    ☐ other (specify): \_\_\_\_\_

Provider's Name: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Provider's Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_

Other Appointment:      DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_      TIME: \_\_\_\_:\_\_\_\_AM/PM

Provider Type:    ☐ case manager    ☐ therapist    ☐ psychiatrist    ☐ other (specify): \_\_\_\_\_

Provider's Name: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Provider's Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_

Other Information:

Department of Mental Health, Mental Retardation, and  
Substance Abuse Services

Discharge Information and Instruction Form  
DMH 924I 0226 (revised 10/19/01)

Page 1 of 3

ADDRESSOGRAPH

# Discharge Information and Instruction Form

Name: \_\_\_\_\_ Registration Number: \_\_\_\_\_

## DISCHARGE DIAGNOSES

Axis I


Axis II

--

Axis III


Axis IV


Axis V    *Current:* \_\_\_\_\_    *Highest in Past Year:* \_\_\_\_\_

Condition on Release:    ☐ *Recovered*    ☐ *Not Recovered, Improved*    ☐ *Unimproved*    ☐ *Not Mentally Ill*

## DISCHARGE MEDICATIONS

MEDICATION NAME	REGIMEN	# PILLS GIVEN

Date Pharmacy Card Mailed: \_\_\_\_/\_\_\_\_/\_\_\_\_ or N/A    Prescriptions Written:    *Yes*    *No*    *N/A*

Other Information:


MD Signature:

Date:

Department of Mental Health, Mental Retardation, and  
Substance Abuse Services

Discharge Information and Instruction Form  
DMH 924I 0226 (revised 10/19/01)  
Page 2 of 3

ADDRESSOGRAPH

**Name:** \_\_\_\_\_ **Registration Number:** \_ \_ \_ \_ \_ - \_ \_ \_ \_ \_

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.

---

---

---

---

---

<i>Facility Staff</i>	<i>Date</i>	<i>CSB Staff</i>	<i>Date</i>
-----------------------	-------------	------------------	-------------

---

*Individual Receiving Services /Date*

<hr/> <i>Legal Guardian/Date</i>	<hr/> <i>Authorized Representative/Date</i>
----------------------------------	---